OneCare Model of Care

2024

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Learning Objectives

- After completing the module, you will be able to:
  - Define OneCare and Model of Care (MOC).
  - Identify the four core elements of the OneCare MOC.
  - Describe eligibility for OneCare participation and identify specialized services for most vulnerable OneCare members.
  - Define Care Coordination, Health Risk Assessment (HRA), Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT).
  - Understand the essential role of the contracted network of providers, adherence to care standards and oversight.
  - Describe the Quality Measurement and Performance Improvement outcomes of the MOC.
  - Define how MOC effectiveness is measured.

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Course Content

- OneCare Model of Care Overview
- OneCare Population
- Care Coordination
- Care Staff Roles and Responsibilities
- Key Components
  - Health Risk Assessment
  - Individualized Care Plan
  - Interdisciplinary Care Team
- Specialty Programs
- Evaluating the Model of Care
- Communication Processes and Methods
- Updates to D-SNP - 2024

Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

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Overview

- The Centers for Medicare and Medicaid Services (CMS) require:
  - All Medicare Advantage Special Needs Plans (MA-SNP) to have a Model of Care (MOC).
  - All employed and contracted personnel and providers of the MA D-SNP are to be trained on the MOC.
  - The OneCare MOC is CalOptima Health's "road map" for care management policies, procedures, and operational systems.
- This course describes the OneCare MOC and how CalOptima Health and the network of contracted providers work together to ensure the success of the MOC and enhance the coordination of care for the members.

What is OneCare?

- OneCare is:
  - CalOptima Health's Medicare Advantage Special Needs Plan
    - Also known as:
      - HMO-SNP
      - SNP-plan
      - D-SNP (Duals Special Needs Plan)
  - Serves people:
    - Eligible and enrolled in CalOptima Health for both Medicare and Medi-Cal (Medicaid) benefits
    - Residing in Orange County
    - Age 21 and older

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Model of Care (MOC)

- A document required by Centers for Medicare and Medicaid Services (CMS) for a D-SNP
  - Defines the care management policies, procedures and operational systems for OneCare
  - Is “member-centric” with the ongoing focus on the member and the member’s family/caregiver
- Four core elements are:
  - Population description of SNP
  - Care coordination
  - Provider network
  - Quality measurement and performance improvement

OneCare Population

- OneCare population description includes:
  - Eligibility to participate
  - Social, cognitive and environmental factors; living conditions; and co-morbid conditions of members
  - Medical and health conditions impacting members
  - Unique characteristics of the population
  - Identification of the most vulnerable members of OneCare with specialized services listed for these members

OneCare Population (cont.)

- OneCare's most vulnerable members are the following special populations:
  - Frail and/or disabled
  - Experiencing or at risk for Homelessness
  - At risk for avoidable hospital or ED admission
  - Serious mental illness and/or Substance Use Disorder (SUD)
  - At risk for institutionalization or long-term care
  - Eligible for Palliative Care (Medi-Cal disease-specific criteria)
  - Homebound
  - Cognitive impairment (Alzheimer's, related dementias or documented dementia care needs)

Knowledge Check

1. What does the acronym OC MOC mean?
    a. Orange Coast Care Model of Orange County
    b. Open Care Coordinator Model of Orange County
    c. OneCare Model of Care
    d. OneCare Medicare Order for Care
2. Care coordination is one of the four core elements of the MOC
    a. True
    b. False

Knowledge Check (cont.)

3. OneCare vulnerable members include those who are:
    a. Frail and/or disabled
    b. Serious mental illness and/or Substance Use Disorder
    c. Homebound
    d. All of the above

Knowledge Check - Answers

1. c. OneCare Model of Care
2. a. True
3. d. All of the above

Care Coordination

- Care coordination includes:
  - Organization of member care activities
  - Sharing information among all the health care participants involved with a member's care
  - Achieving safer and more effective care
  - Closed-loop coordination of all benefits, including Medicare, Medi-Cal, LTSS
- Main goal of care coordination is:
  - To meet members' needs and preferences in the delivery of high-quality, high-value health care

Care Coordination (cont.)

- Care coordination components include:
  - Staff structure
    - Administrative, clinical, and oversight roles specific to OneCare including a Personal Care Coordinator (PCC)
  - Health Risk Assessment (HRA)
    - Assessment of the OneCare members' health and social needs
  - Interdisciplinary Care Team (ICT)
    - The ICT includes the member's PCP, Case Manager, and others, as appropriate. Each OneCare member has a care team to ensure care coordination occurs in a structured collaborative process. The team is involved in the creation and updates of the ICP. They may have formal meetings as needed to discuss the member's care, review the ICP and ensure care coordination occurs as appropriate.

Care Coordination (cont.)

- Care coordination components include:
  - Individualized Care Plan (ICP)
    - A plan of care for the OneCare member based on information from the HRA
  - Care transition protocols
    - Guidelines on how to manage the OneCare member across the care continuum

Staff Structure and Roles

- Organized to align with essential care management roles:
  - Administrative
  - Personal Care Coordinator (PCC)
    - At CalOptima Health
    - At contracted health networks
  - Clinical
  - Oversight

Administrative

- Manages:
  - Enrollment
  - Eligibility
  - Claims
  - Grievances and provider complaints
  - Information communication
  - Collection, analysis, and reporting of performance and health outcomes data

Personal Care Coordinator (PCC)

- At CalOptima Health
  - Administers the HRA for each member
    - Initial and annual
    - May be face-to-face, virtual, telephonic, or paper-based
    - Enters HRA responses into data platform for RN review
    - Note — HRA collection not delegated to the health networks
  - Communicates key event triggers to the health network
    - For example, significant changes in a member's medical condition
  - Conducts warm transfer calls of the member to the health network
  - Maintains knowledge of all benefits including Medicare, Medi-Cal, and LTSS

PCC (cont.)

- At a health network:
  - Member’s point of contact and liaison between the member, provider, health network and CalOptima Health
  - Role:
    - Guides member in understanding and accessing their benefits with awareness of all Medicare, Medi-Cal and LTSS benefits
    - Schedules, facilitates, and participates in ICT meetings, as appropriate
    - Assists member with scheduling appointments, facilitate referrals
    - Assists with coordination of member's health care needs
    - Notifies member's care team of key events
    - Facilitates communication of ICP to Primary Care Provider (PCP) and other care team members, including member

Clinical Staff

Examples of clinical staff may include:

- PCP
- Registered Nurse (RN) Case Manager
- Licensed Clinical Social Worker (LCSW)

Roles:

- Advocate for, inform and educate members
- Coordinate care
- Identify and facilitate access to community resources
- Educate members on health risks and management of illnesses
- Empower members to be advocates of their health care
- Maintain and share records and reports
- Assure HIPAA (Health Insurance Portability and Accountability Act) compliance

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Oversight

- CalOptima Health and the health networks collaborate to support the MOC.
- Role:
  - Monitor MOC implementation
  - Evaluate effectiveness of the MOC
  - Assure licensure and competency
  - Assure statutory and regulatory compliance
  - Monitor contractual and delegated services
  - Monitor Interdisciplinary Care Teams
  - Assure timely and appropriate delivery of services
  - Assure providers use evidence-based clinical practice guidelines
  - Assure seamless transitions and timely follow-up

Health Risk Assessment

- Process:
  - CalOptima Health PCC:
    - Administers initial HRA and annual HRA for each member
    - Uses a standardized HRA tool
      - Note — HRA completion is not delegated to health network
  - May be completed face-to-face, virtual, telephonic, or paper-based
  - Identified care needs are categorized into Care Domains:
    - Physical Health, Behavioral Health, LTSS, Access to Care, Care Coordination, and promotion of Self-Management/Health and Wellness Monitoring

Health Risk Assessment (cont.)

- Process (cont.):
  - Used by clinical staff to evaluate the medical, psychosocial, cognitive, functional needs, caregiver status, and current services received with medical and behavioral health history
  - Used to develop a member's Individual Care Plan (ICP)

Interdisciplinary Care Team

- Role and process:
  - All OneCare members have an Interdisciplinary Care Team
  - Includes the member's medical, behavioral, and ancillary providers
  - Convenes as appropriate to manage the member's care and assure care coordination
  - Analyzes and incorporates the results of the initial or annual HRA into the ICP, utilizing evidence-based guidelines
  - Collaborates to develop the member's ICP annually, or to update the member's ICP with changes in health care status
  - Manages the medical, cognitive, psychosocial, and functional needs of each member

Interdisciplinary Care Team (cont.)

- Role and process (cont.):
  - Communicates the ICP to all caregivers for care coordination
  - Provides a copy of the ICP to the member in the member's preferred language, font and print size

Interdisciplinary Care Team (cont.)

- Formal vs. Informal ICT
  - All OC members have an Interdisciplinary Care Team
  - All OC members should have evidence of Informal ICT collaboration
    - Examples include:
      - Collaboration with the PCP and other Specialists
      - Input from members of the ICT into the ICP
  - Formal ICT meetings will be held for:
    - High Risk members
    - Any members enrolled in Care Coordination or Complex Case Management
    - Member identified in a vulnerable population
      - Must use a Palliative Care ICT for those members enrolled in Palliative Care
    - If member or PCP requests

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Composition of the ICT Meeting

- ICT composition is determined by member's needs and preferences

Core Participants:
• Member and/or designated representative • PCP assigned to member

Additional Participants:
• Behavioral health specialist • Pharmacist • Case manager • Health network PCC • Therapist (speech and/or physical) • Nutritionist • Appropriate specialist • Health educator • Disease management specialist • Social worker • LTSS Liaison • Dementia Care Specialist

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Individualized Care Plan (ICP)

- Process:
  - Developed by ICT for **each** OneCare member
  - Includes the member's personalized goals and objectives, specific services and benefits and measurable outcomes
  - Goals and objectives prioritized by the member's preference
  - Written ICP communicated to member, caregivers and providers
  - Members and/or caregivers (at member request) given a copy of the ICP and asked to sign off
  - Written ICP reviewed and revised annually by PCP or ICT or when health status changes
  - Accessible to all care providers
  - Records maintained per HIPAA and professional standards

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ICP Communication

- The ICP is shared with the PCP with request to review, provide additional feedback if appropriate, and sign the ICP.
- The ICP is also shared with appropriate specialty providers and ICT participants.

Self-Directed Care

- Self-direction enables members to live independently in their own home and in their community.
- When members self-direct their care, they hire their caregivers and become the caregiver's employer.
- Members decide what services they need, when they need them, and how they would like to receive them.
- Self-Directed Care empowers members to have choice over their own care and lives.

Knowledge Check

1. Who administers the initial HRA?
    a. Member's doctor
    b. Member's care giver
    c. CalOptima Health PCC
    d. Member's care coordinator
2. Who develops the member's ICP?
    a. Member's care coordinator
    b. ICT
    c. Health network PCC
    d. Member's caregiver

Knowledge Check (cont.)

3. The purpose of care coordination is to organize and coordinate the member's care activities.
    a. True
    b. False

Knowledge Check - Answers

1. c. CalOptima Health PCC
2. b. ICT
3. a. True

OneCare Provider Network

- CalOptima Health:
  - Contracts with board-certified providers
  - Monitors network providers to assure they use nationally recognized clinical practice guidelines
  - Assures that network providers are licensed and competent through a formal credentialing review
  - Maintains a broad network of specialists that include palliative care, pain management, chiropractors and psychiatrists
  - Monitors network adequacy to ensure access to care
  - Provides training on OneCare MOC for the providers and those who routinely interact with OneCare members:
    - Assures provision and attestation of initial and annual MOC training

OneCare Provider Network (cont.)

- OneCare provider network includes:
  - Primary care providers
  - Specialized expertise:
    - Specialists, hospitalists, pharmacists, crisis teams
    - Skilled nursing facility (SNF)
    - Behavioral health providers
    - Palliative Care Providers
    - Allied health providers, ancillary services
    - Substance abuse detoxification and rehabilitation services
  - Use of evidence-based clinical guidelines and care transition protocols:
    - Formalize oversight of provider network adherence to nationally recognized care standards.

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OneCare Programs and Services

- OneCare specialty programs and services include:
  - Behavioral health
  - Specialty services:
    - Dialysis
    - Transportation
    - Durable Medical Equipment (DME)
    - Home health
  - Psychosocial programs such as drug and alcohol treatment

OneCare Programs and Services (cont.)

- Referrals to:
  - Community-Based Adult Services (CBAS)
  - In-Home Supportive Services (IHSS)
  - Community Supports (CS)
  - Housing assistance
  - Meals on Wheels
  - Personal finance counseling

OneCare Programs and Services (cont.)

- Disease management and health education programs
- Community-based resources, such as:
  - Aging & Disability Resource Connection of Orange County (ADRCOC)
  - Alzheimer's OC
  - Multi-Purpose Senior Services Program (MSSP)
  - Office on Aging (OOA)
  - Dayle McIntosh Center (Independent Living Center)

Evaluating the Model of Care

- CMS defines processes and tools to measure health care outcomes.
  - Purpose is to ascertain that health plans provide high-quality health care for their members.
- Processes include:
  - Quality measurement (QM)
  - Performance improvement (PI)

Evaluating the Model of Care (cont.)

- Methods include:
  - MOC Quality PI Plan
  - Measurable goals and health outcomes measurements
  - Measuring patient experience of care
  - Ongoing performance improvement evaluation
  - Dissemination of SNP quality performance related to the MOC

Performance Measurement

- Uses standardized quality improvement measures to measure performance and health outcomes such as:
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - Disease management measures
  - Utilization management measures
  - Member satisfaction (surveys)
  - Provider satisfaction (surveys)
  - Ongoing monitoring of complaints and grievance summaries
  - Tracking and assessing completion of MOC training

Measurable Goals

- Evaluates measurable goals that:
  - Improve coordination of care
  - Appropriate utilization of services for preventative health and chronic conditions
  - Improve member experience
  - Enhanced care transitions across all healthcare settings and providers

Measurement of Effectiveness

- Evaluates measures of effectiveness by collecting and reporting data on:
  - Improvement in access to care
  - Improvement in member health status
  - Staff implementation of MOC
  - Comprehensive HRA
  - Implementation of ICP
  - Provider network of specialized expertise
  - Application of evidence-based practice
  - Improvement of member satisfaction and retention

OneCare Clinical Guidelines

- Supports the physician management of chronic conditions
  - Disseminates best practices, evidence-based guidelines
  - Shares provider tool kits to promote education and adherence

Communication Processes and Methods

- Utilizes an integrated system of communication for members and providers on both a scheduled and as needed basis
- Methods include:
  - Member newsletters
  - CalOptima Health website
  - Networking and focus group sessions
  - Conferences: face-to-face, telephonic, electronic
  - Committees:
    - Utilization Management Committee (UMC)
    - Quality Assurance Committee (QAC)
    - Member Advisory Committee (MAC)
    - Provider Advisory Committee (PAC)

Knowledge Check

1. CalOptima Health monitors network adequacy to ensure members have access to care.
    a. True
    b. False
2. Specialty programs or services for OneCare members include:
    a. Behavioral health
    b. Health education
    c. Durable Medical Equipment (DME)
    d. All of the above

Knowledge Check (cont.)

3. OneCare develops their own quality improvement measures to measure performance and health outcomes.
    a. True
    b. False

Knowledge Check - Answers

1. a. True
2. d. All of the above
3. b. False

LTSS Liaison

- OneCare must have staff to serve as liaisons for the LTSS provider community to help facilitate member care transitions.
- These staff must be trained to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules.
- Staff serving as liaisons for the LTSS provider community must participate in the ICT, as appropriate.

Dementia Care Specialists

- OneCare has *Dementia Care Specialists* who have received intensive training through Alzheimer's Orange County.
- The training includes understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers.
- The Dementia Care Specialist must participate in formal ICT meetings for members with dementia.

Dementia Care Specialists (cont.)

- The care team for members with documented dementia care needs must include the member's caregiver and a trained Dementia Care Specialist to the extent possible and as consistent with the member's preferences.
- These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.
- The ICP should also include any referrals to Community Based Organizations such as those serving members with dementia (e.g. Alzheimer's organizations).

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Updates to OneCare - 2024

- Enhanced Care Management (ECM) updates
- Face-to-Face Requirements
- Palliative Care
- Dementia Care Aware
- Continuity of Care

Enhanced Care Management (ECM)

- OneCare members may meet the criteria for an ECM population of focus.
- There is overlap with the D-SNP Model of Care and ECM requirements, which could result in confusion for members if they receive services from both programs.
- OneCare is responsible for providing ECM-like services to members who are eligible and agree to enroll.
- ECM-like services are provided primarily through in-person contact.

Face-to-Face Requirement

- OneCare is required to provide a face-to-face encounter for the delivery of health care or care management or care coordination services between the member and a member of their care team or the case management team.
- The main purpose of the face-to-face encounter is to promote and ensure OneCare members are seen and clinically assessed at least annually by their PCP or specialist serving as the PCP.
- CalOptima Health will track and monitor OneCare members to ensure they have or are offered a face-to-face encounter at least annually.

Palliative Care

- Palliative Care is available to OneCare members effective 2024.
  - Eligibility criteria is outlined in the D-SNP Policy Guide.
    - D-SNP Policy Guide can be found at DHCS.ca.gov
  - Providers must be educated on the program and process to make referrals.
  - OneCare members enrolled in a Palliative Care program:
    - The Palliative Care Coordinator serves as lead Care Manager.
    - Must use a Palliative Care ICT meeting.
    - Palliative Care is part of the member's care team.
    - The ICP is developed and updated by, and/or shared with the Palliative Care team as appropriate.

Dementia Care Aware

- Face-to-Face encounters and/or responses to the HRA may indicate potential cognitive impairment.
  - Members should be referred to their providers for further diagnostic evaluation when appropriate.
  - Provider should conduct a full diagnostic workup when memory concerns are identified.
- The Dementia Care Aware training and resources are available to support providers when detecting cognitive impairment.

Continuity of Care

- May be telephonic requests from Member, Authorized Representative, or treating Providers.
  - Includes DME and Medical Supply Providers.
- Requests will be completed within:
  - 30 calendar days from request;
  - 15 calendar days if Member's medical condition requires immediate attention; or
  - 3 calendar days if there is risk of harm to the Member.
- Member notification within 7 calendar days of completion.

Continuity of Care (cont.)

- Must notify Member 30 calendar days before the end of the continuity of care period.
- Must allow the Member to continue treatment for up to the 12-month continuity of care period.

Model of Care Summary

- OneCare's Model of Care:
  - Defines and creates a comprehensive strategy and infrastructure for care of our members
  - Meets the unique needs of the dual-eligible population by:
    - Setting agency-wide strategic goals
    - Contracting with expert practitioners
    - Striving to meet each member's unique medical, psychosocial, functional and cognitive needs

Acronyms List

ADRD	Alzheimer's Disease and Related Dementias
CBAS	Community-Based Adult Services (formerly Adult Day Care)
CMS	Centers for Medicare and Medicaid Services
CS	Community Supports
DME	Durable Medical Equipment
ECM	Enhanced Care Manageemnt
QAC	Quality Assurance Committee
HEDIS	Health Care Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act

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Acronyms List

HRA	Health Risk Assessment
ICP	Individualized Care Plan
ICT	Interdisciplinary Care Team
IHSS	In-Home Supportive Services
LCSW	Licensed Clinical Social Worker
LTSS	Long-Term Services and Supports
MAC	Member Advisory Committee
MOC	Model of Care
MSSP	Multi-Purpose Senior Services Program
PAC	Provider Advisory Committee

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Acronyms List

PCC	Personal Care Coordinator
PCP	Primary Care Physician
PI	Performance Improvement
QM	Quality Measurement
RN	Registered Nurse
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SUD	Substance Use Disorder
UMC	Utilization Management Committee

Authorities

- H5433_2024 D-SNP MOC final

References

- CalOptima Health Policy GG.1204: Clinical Practice Guideline
- CalOptima Health Policy EE.1103: Provider Network Training
- CalOptima Health Policy MA.6032: Model of Care
- CalAIM Dual Eligible Special Needs Plans: Policy Guide: Contract Year 2024

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